Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, D.C. 20554

In the Matter of	)	
	)	
Promoting Telehealth in Rural America	)	WC Docket No. 17-310
	)	

REPLY COMMENTS OF THE NEW ENGLAND TELEHEALTH CONSORTIUM

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COMMENTS OF THE NEW ENGLAND TELEHEALTH CONSORTIUM

The New England Telehealth Consortium (NETC) has over 900 health care participants spanning six New England states and participates as a consortium in the Healthcare Connect Fund (HCF). NETC, by its attorney hereby submits these comments in the above-captioned proceeding.

NETC was established in 2006 as part of the Rural Health Care pilot program. Leveraging one of the largest awards in that program, NETC designed an efficient state-of-the-art network dedicated to the needs of healthcare, implemented a network operations center, and leveraged universal service funding and competitive bidding to reach long-term cost-effective contracts with multiple private carriers in the region with middle- and last-mile network facilities. The core NETC network spans three states – Maine, New Hampshire, and Vermont – with redundant network cores and independent links to the Boston area for internet access. NETC's efficient network design and long-term contracts have delivered secure, high-availability network services for healthcare, while reducing costs and dramatically increasing the availability of affordable bandwidth to health care providers across the region. As health care systems across six New

England states link their networks to the NETC regional network, NETC has realized the FCC's goal of establishing a network-of-networks for our region.[1]

I. COMMENTERS RECOGNIZE THE RURAL HEALTH CARE PROGRAM IS MORE IMPORTANT THAN EVER TO RURAL AMERICA AND GENERALLY SUPPORT A LARGER PROGRAM

Commenters universally recognized the importance of the Rural Health Care program and generally supported more funding to fulfill Congressional policies and mandates for universal service for healthcare. However, several commenters urged the Commission not to provide more funding to the Telecommunications Program – at least as it operates outside of Alaska (the "lower 48") – until after appropriate reforms are implemented.

For example, USTelecom acknowledged that the RHC governing statute "makes no mention of a budget" and USTelecom qualifiedly "has no objection to revising the size of [the RHC] cap with an eye toward increasing it."[2] USTelecom went on to note "[a] persistent scarcity of doctors, specialists, and other medical resources in rural areas have made broadband telecommunications connectivity into one of the most fundamental necessities of modern rural medical care."[3] While USTelecom does not favor increasing funding for the Telecom Program in the lower 48, it appears to support more funding for the Telecom Program in Alaska,[4] and does

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[1] *See Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 21 FCC Rcd 11111, ¶ 10 (2006) (*2006 Pilot Program Order*) ("[the] comprehensive network [funded through the Pilot Program] will provide the health care communities access to the various technologies and medical expertise that reside in specific hospitals, medical schools, and health centers within a region or state.").

[2] USTelecom Comments at 8.

[3] *Id.*

[4] *Id.* at 6 ("while USTelecom believes that the Commission should ensure sufficient Telecom Program funding for Alaska to achieve the statutory mandate of reasonably comparable urban and rural healthcare provider rates, changes to the Telecom Program budget should await a fuller but speedy review and overhaul of that program").

not appear to object to increased funding in the HCF to update the program cap to reflect current realities:

> Certainly, transformative changes in the healthcare industry and the program itself since 1997 have increased demand for rural telehealth and telemedicine services. Since 1997, technology has exponentially increased the range of medical services that can be delivered remotely; portable and electronic health records have become a focus of national public policy; and the Commission has increased the scale and scope of the RHC Program to include skilled nursing facility applicants, support for a greater range of equipment, facilities, and increased support for broadband Internet access services from 25 percent to 65 percent of the retail rate of services under the Healthcare Connect Fund (HCF) Program.").[5]

NETC agrees the Telecom Program, particularly as it operates in the lower 48, needs reforms. Because the HCF does not appear as vulnerable to abuse as the Telecom Program in the lower 48, encouraging migration from the Telecom Program to an improved HCF should be one of those reforms. We discuss this further below.

Other carrier associations did not object to increasing the size of the RHC program. Both NTCA—The Rural Broadband Association and NCTA—The Internet & Television Association recognized the importance of the RHC program to rural America and urged that program funding be used as efficiently as possible.[6] The Satellite Industry Association (SIA) also did not object to a larger RHC program and supported program improvements that would recognize the key

[5] *Id.*; *but see* January 25, 2018, AT&T *ex parte* notice (discussing Telecom Program and other RHC reforms and recommending reforms be adopted before increasing the program cap).

[6] *See, e.g.,* NCTA Comments at 1 (supporting improvements to the RHC programs "to ensure the funds are used responsibly and appropriately"); NTCA Comments at 1 (supporting the "overarching goal to facilitate greater provision of telehealth in rural America" while ensuring that any program changes are data driven).

contribution of satellite providers – particularly with respect to providing back-up connectivity and redundancy in areas affected by natural disasters.[7]

NETC has utilized satellite services and has found that although satellite connections are not optimal for some telemedicine applications, satellite services can be critical in remote areas to provide redundant back-up connectivity. More RHC funding will be critical to ensuring rural health care providers everywhere are prepared for disaster-caused outages which experience in Puerto Rico has shown can last for a considerable time. NETC, because of a network design that includes redundant network cores, has not suffered a single network outage since it became operational in early 2013.

II. THE HEALTHCARE CONNECT FUND IS ACHIEVING THE OBJECTIVES SET BY THE COMMISSION IN 2012

A. Consortia with Non-Rural Members Foster Cost-Effective Network Deployments and Should Be Encouraged

The Order accompanying the NPRM effectively de-prioritized HCF consortia for FY 2017 based on the rationale that consortia had already benefitted from bulk-buying discounts and so could better absorb pro-rata reductions. The NPRM considers potential de-prioritization proposals that could affect consortia in future funding years. The rationale of consortia

[7] SIA Comments at 1, 5 ("As recently expressed by FCC Chairman Pai: 'Access to reliable communications services during times of emergency is critical to enabling Americans in danger to request help and our heroic first responders to do their jobs.' Following . . . recent hurricanes which swept through the United States as well as in the Caribbean, SIA members provided satellite services to restore communications for disaster relief and emergency response organizations at the local, state, and federal levels. These services have also allowed for the reopening of critical infrastructure, including hospitals. For example, in Puerto Rico, Hughes and ResponseForce1 provided support to the San Cristobal Hospital in Ponce by deploying VSATs and solar generators to restore operations and communications at the hospital, enabling the hospital staff to order additional supplies and medications, as well as evacuate critical patients.") (footnotes omitted).

benefiting from bulk-buying price reductions is faulty as such reductions are not always available to consortia. Moreover, consortia provide other benefits to the program and to small unaffiliated health care providers that should not be ignored. For example, as SHLB noted in its initial comments, HCF consortia incent more efficient network design than with individual applicants obtaining point-to-point connections, thereby lowering program demand.[8]

Rural Nebraska Healthcare Network (RNHN) (who is not a SHLB participant) further supported these points, explaining:

> [The] broad assumption that consortia have advantages of bargaining power or economies of scale in purchasing services in the case of RNHN is false. When we posted our RFPs for FY 2017, we received no responses to one request and one response to another request. Broadband services are still lacking in rural areas and consortia have to pay fees based on services available not necessarily based on bargaining power. Consortia can eliminate or reduce administrative burden for individual providers, but not always provide economies of scale. As [we have] explained, [the] RNHN Consortium is made up of small rural individual healthcare providers and they are at equal risk from harm due to proration [as non-consortium participants].[9]

NETC offered similar observations in our initial comments and agree with RNHN.[10]

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[8] SHLB Comments at 26-30 (noting, among other things, that the FCC has recognized that consortia network foster more efficient network design); *see also HCF Order* at ¶ 54, n.137 (recognizing that "it may be more efficient to design the middle-mile component of a regional or statewide network by using connections between non-rural sites, rather than routing traffic through a rural site.") (citation omitted). Here, the FCC effectively recognizes that networks can be designed inefficiently – unnecessarily and inefficiently routing connections through an eligible rural location – so as to qualify for an RHC subsidy.

[9] RNHN Comments at 2.

[10] NETC Comments at 4 ("[B]uying power varies by contract and NETC's use of the HCF to interconnect small adjoining networks of just a few HCPs, does not generally result in volume discounts. Thus, the Commission's premise that 'consortia' are all benefiting from unusually low pricing as compared to individual applicants is only occasionally true.")

Some commenters argue that providing support to non-rural participants in consortia is inconsistent with the purposes of the RHC program.[11] To understand why this is a largely misplaced concern, it is critical to recognize that most connections supported in the history of the RHC program have terminated in an urban or non-rural location. Thus, the RHC program has always subsidized the urban "end" of a point-to-point connection. The HCF consortium model creates a more rational model: instead of subsidizing many point-to-point connections to multiple different urban providers offering telemedicine services (for example), the HCF consortium model supports a larger connection to a ring (or cloud) to which those multiple urban providers are connected.

Encouraging efficiently designed networks was one of the principal purposes of the RHC Pilot Program and the HCF consortium model. To say simply that urban health care providers should not receive support ignores the fact that – in effect – they always have. Indeed, USAC and the FCC recognized that a single rural health care provider could originate a network that connects unlimited non-rural locations through the rural location. The Bureau previously explained this phenomenon as follows:

> *Efficiency of Network Design*. In addition, network design in many cases has been more efficient and less costly in the Pilot Program than in the Primary Program, because the Pilot Program funds urban locations. Under the Primary Program, circuits are only eligible for funding if one end of the circuit terminates at an eligible rural entity, which can incentivize HCPs to maximize funding by ensuring that all connections within the network terminate at an eligible rural entity. As a technical and financial matter, this can lead to less efficient network design. For example, it may be more efficient to design the middle-mile component of a regional or statewide network by using connections between urban

[11] *See, e.g.,* Comments of the National Association of Community HealthCenters (NCHC) at 10-11; National Rural Health Association (NHRA) Comments at 3-4.

> sites. Pilot projects were able to design their networks with maximum network efficiency in mind, since there is no negative impact on funding from including urban nodes within the network.[12]

As inefficient as this can be, networks intentionally designed to originate at a rural location to maximize RHC support are allowed under current program rules. Banning or making it more difficult for non-rural health care providers to participate in HCF consortium would simply encourage more of this inefficient behavior – likely creating even greater Telecom Program demand in the lower 48 where the average discount rate is 91 percent rather than the 65 percent subsidy available in the HCF.[13]

This is one reason that NETC respectfully disagrees with NRHA that urban health care providers already need to have a connection to the cloud for other purposes and so an RHC subsidy is not necessary. NRHA seems to be suggesting that access to the Internet cloud is all that is needed to provide telemedicine and telehealth.[14] In NETC's experience, however, while access to the Internet is important, access to dedicated private network services are what in-region health care providers need to reach each other and to provide telemedicine consults. While NETC is over 85 percent rural, our non-rural participants are connected to our private network and every participant on our network can thereby reach every other participant on the network with a dedicated private connection, without ever touching the Internet. From a

[12] *See Wireline Competition Bureau Interim Evaluation of Rural Health Care Pilot Program Staff Report*, WC Docket No. 02-60, Staff Report, 27 FCC Rcd 9387, at 60-61 (2012) (footnotes omitted; citing USAC data).

[13] *See Promoting Telehealth in Rural America, Notice of Proposed Rulemaking and Order*, WC Docket No. 17-310, FCC 17-164, ¶ 12 (Dec. 18, 2017) (*NPRM and Order*).

[14] *See* NRHA Comments at 3.

security and quality of service standpoint, this is the optimal configuration for healthcare. Having urban participation is critical to making such networks viable.

NRHA also suggests that non-rural health care providers are already compensated through telemedicine reimbursement and thus do not need the RHC subsidy. As NETC noted in its comments, however, urban health care providers do pass their broadband costs off to rural health care providers, so rural pays no matter what. NETC also disagrees with NRHA's suggestion that urban health care providers participating in the RHC program be forced to demonstrate that their HCF funding is "purely for the benefit of the rural participants in the consortia."[15] NETC would support a requirement, however, that urban providers within a consortium be in contiguous states with the network to which they belong – unless the consortium can attest that an urban site in a non-contiguous state is in fact exchanging information with at least one of the rural sites in the consortium.[16] This would at least prevent the situation where an urban hospital in New York City (for example) joins a consortium with a rural provider in North Dakota (for example), simply to obtain an RHC subsidy. Finally, other commenters noted the benefits of

[15] *See* NRHA Comments at 4. AHA similarly opposes this proposal by NRHA as unnecessarily burdensome. *See* AHA Comments at 14.

[16] This would be a less stringent standard than the Commission's proposal that non-rural health care providers be required to demonstrate a "direct healthcare-service relationship between an HCF consortium's non-rural and rural healthcare providers that receive Program support." *See NPRM and Order* at ¶ 39.

consortia with urban participating such as the American Hospital Association (AHA),[17] Illinois Rural HealthNet (IRHN)[18] and SHLB.[19]

B. The Healthcare Connect Fund Has So Far Proven Less Attractive for Abuses than the Telecom Program

The HCF program was established in 2012 and has been operational since 2013, almost five years. The two recent RHC enforcement cases alleging serious large-scale abuses in the lower 48 Telecom Program both occurred since the HCF was established, but neither contained allegations of HCF-related abuses.[20] There are thus no known cases of apparent fraud or abuse in the HCF program.

NETC recognizes that the Telecom Program is statutorily mandated and continues to be vitally important in Alaska and for certain rural locations in the lower 48 where the 65 percent HCF subsidy (35 percent match) may not be sufficient to support needed connectivity. Nevertheless, there are certain characteristics of the Telecom Program as it operates in the lower 48 that may make it more prone to abuse than the HCF.

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[17] AHA Comments at 12-14.

[18] IRHN Comments at 3 (noting success of FCC investing through the RHC Pilot Program in its successful statewide broadband network now offering Gigabit speeds when only T1 (or less) levels of service were previously available).

[19] SHLB Comments at 26-30; *cf.* Joint Comments of Franciscan Health Alliance and Parkview Health System at 5 (noting network security imperatives driving cloud network adoption), 13-14 (noting antiquation of point-to-point network configurations).

[20] *See DataConnex, LLC*, Notice of Apparent Liability For Forfeiture And Order, FCC 18-19 (rel. Jan. 30, 2018) (*DataConnex NAL*) (apparently undisclosed financial relationship between service provider and consultant corrupted competitive bidding processes for numerous health care providers participating in lower 48 Telecom Program); *Network Services Solutions, LLC, Scott Madison,* Amendment to Notice of Apparent Liability for Forfeiture and Order, 32 FCC Rcd 5169 (2017) (*NSS Amended NAL*) (apparent violations of competitive bidding and rural and urban rate requirements in the lower 48 Telecom Program).

The differences between how the HCF and the Telecom Program calculate support may account for this. With the flat-rate 65 percent subsidy in the HCF, every participating health care provider, individually or in a consortium, has significant financial skin-in-the-game. If the price for a service is high, the health care provider pays proportionally more for the service. This effectively aligns a health care provider's interests with that of the FCC in the HCF: both want to pay the lowest price possible for the service that otherwise meets the needs of healthcare.[21]

In contrast, the Telecom Program, calculates support as the difference in price between the rural rate (the rate charged), and an available urban rate for the same or similar service. A higher *rural* rate does not affect the amount paid by the health care provider whereas a lower *urban* rate does. Although a lower urban rate does not increase the total amount paid to the carrier, carriers are apparently gaining a competitive advantage in the lower 48 Telecom Program by identifying or supplying their customers with low urban rates.[22] Although health care providers are ultimately responsible to adhere to program rules, in some cases consultants and carriers in the lower 48 appear to be taking advantage of these Telecom Program characteristics.[23]

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[21] *See also* Joint Comments of Franciscan Health Alliance and Parkview Health System at 15-16 (noting the match requirement "ensures HCF program participants are efficient in their use of RHC program funds.").

[22] *See, e.g,. DataConnex NAL* at ¶ 26. Notwithstanding, health care providers are supposed to select vendors based on the rural rate, not the urban rate. *See, e.g.,* Federal-State Joint Board on Universal Service, CC Docket No. 96-45, Report and Order, 12 FCC Rcd 8776, 9093-9161, ¶ 687 (1997) (*First Report and Order*) (subsequent history omitted) ("*After being selected* [*in a competitive bidding process focusing on the total cost of service*], the carrier shall certify to [USAC] the urban rate, the rural rate, and the difference sought as an offset against the carrier's universal service obligation.") (emphasis added).

[23] NETC itself was approached about 16 months ago by persons who claimed to represent a carrier (not DataConnex or NSS) that only provides services through the Telecom Program, proposing that if NETC would participate in the Telecom Program NETC participants would obtain a higher RHC subsidy, while implying the carrier could arrange for itself to be selected as part of the competitive bidding process. NETC declined the offer.

For example, in *DataConnex,* the most recent RHC enforcement action, consultants working for health care providers apparently also received financial kick-backs from a service provider (unbeknownst to the health care providers). The consultants were ostensibly representing the health care providers but were apparently receiving payments from DataConnex while selecting DataConnex as part of the bid process, without apparent regard to whether DataConnex was offering competitively priced services. It is doubtful such a scheme would have worked in the HCF because the health care providers would have more price sensitivity, paying at least 35 percent of the total cost of service instead of paying the urban rate regardless of the total cost of the service and thus being effectively insulated from the cost of the service.

In addition, consortia lead entities, which by FCC rule must be not-profit entities,[24] provide many of the same services to individual health care providers that for-profit consultants provide. The reality is individual health care providers typically will not undertake the RHC application process in either the Telecom Program or HCF without outside assistance. While consortia themselves may employ consultants, because of their size and experience, consortia tend to be more sophisticated users of such services than individual applicants.[25] HCF consortia thus present an alternative for individual applicants that is less prone to potential consultant abuse.

NETC is not arguing that the Telecom Program is flawed – only that because of the way the program is structured it may need greater FCC oversight (at least in the lower 48), than the

[24] *See* 47 C.F.R. § 54.631(b).

[25] *See* n.23, *supra.*

HCF. While NETC supports having consistent rules around competitive bidding, gifts, and consultants across E-rate, HCF, and the Telecom Program, NETC agrees generally with commenters that caution that more burdensome rules and processes are not the most effective way to address fraud and abuse.[26] In addition to increased oversight, however, encouraging greater participation in the HCF may be a simple and effective way for the Commission to address any apparent problems with the Telecom Program in the lower 48.

C. A Modestly Reformed Healthcare Connect Fund Will Make More Efficient Use of Limited Funding than the Telecom Program in the Lower 48

One way to encourage migration from the lower 48 Telecom Program to the HCF is to offer higher HCF subsidies to eligible HCPs in the most rural areas. While this would reduce the skin-in-the-game in the HCF for these participants, the flat rate subsidy will always provide greater price-sensitivity for health care providers than a fixed urban rate. NETC (which is a member of the SHLB Coalition) thus endorses the SHLB proposal to create Frontier and Extremely Rural discount tiers in the HCF.[27]

And, as noted above, HCF consortium themselves encourage more efficient use of universal service funds. Rather than fostering a tangle of point-to-point connections, all connecting urban and rural, consortia foster shorter-hop connections to a shared ring or hub.

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[26] *See* SHLB Comments at 20 (supporting recent enforcement activity and observing that enforcement "may be more efficient in protecting the program from waste, fraud, and abuse than imposing burdensome new rules"); *cf.* NRHA Comments at 3 (arguing that "necessary and laudable goal [of reducing fraud, waste, and abuse in the RHC program] can be achieved without increasing administrative complexity" and noting that greater complexity leads to greater involvement of consultants in the programs); Critical Access Hospital Coalition at 2 ("Intentional violations [of RHC program rules] should be met with swift and direct consequences to the service provider, not the unknowing HCP.").

[27] SHLB Comments at 15-17.

This leads to more efficient use of funds both from a network design standpoint, and from a bulk-buying standpoint.

III. CONCLUSION

We urge the Commission to increase the overall size of the RHC program to reflect new technologies, economic realities, and congressional intent. We urge the Commission to rely more heavily on majority rural HCF consortia to ensure limited RHC program funds are used as efficiently as possible.

Respectfully submitted,

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